

Medication Authorization – Single Use

(OAR 414-360-0230(1)(b))

Child's Name: _____

Medication Name: _____

Reason for Medication: _____

Dosage: _____

Dates to Administer: _____

Times to Administer: _____

How to Give Medication: _____

Refrigeration Required? Yes No

Authorization:

I authorize Chickadee Ridge Early Learning Center staff to administer the above medication to my child according to the instructions provided. This permission applies only to the specific dates listed above.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____